4.430 Payment Rates After the Start-Up Period
After completion of the start-up period, rates for a significantly expanded provider may be reestablished based on at least a six-month cost report which will begin after the end of the start-up period or after the end of the cost reporting period used in Section 4.420. The minimum patient day occupancy standards under Section 3.000 shall apply. Section 4.430 may be applied to the significantly expanded provider which does not receive a retrospective adjustment under Section 4.420.

4.432 Modified Cost Report Period
The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.360.

4.433 Base Rates
The base rates for a significantly expanded facility are described in Section 3.722, item 3.

4.435 July 1 Payment Rates
A base cost reporting period shall be designated by the Department for establishing an expanded facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the start-up period includes the July 1 date, July payment rates may be established under the retrospective provisions for the start-up period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the start-up period, the Department may designate a more current base cost reporting period for July 1 rates.

4.460 Property Tax Allowance
The property tax allowance shall be based on the provisions of Section 3.400. Nevertheless, the provider may request the property tax allowance for an expanded facility to be adjusted if the expense in the previous tax allowance had been based on an assessment date prior to the month of licensure. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is received by the Department. The adjustment shall only consider current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the support services allowance in the January 1 payment rate.

4.500 PAYMENT RATES FOR SIGNIFICANT DECREASES IN LICENSED BEDS

4.501 General
A provider may plan to significantly decrease its number of unrestricted use licensed beds. The Department may require or the provider may request payment rates to be reestablished. If the provider makes the request, the provider must notify the Department in writing prior to the effective date of the reestablished rates and must relinquish the future use of a significant number of licensed beds. Any future use of the relinquished beds must be approved, if required, under Chapter 150, Wis. Stats. The Department may deny rate adjustments under this section if it determines the provider's decrease is not desirable or appropriate.

If the reduction involves an extended and major phase-down, the provider may elect to have rates established under the provisions of Section 4.560 below. If Section 4.560 is not applied, the rate computation will consist of two phases: (1) retrospective rates for the phase-down period, and (2) post phase-down adjusted rates. A significant decrease is defined in Section 1.304. The property allowance shall be recalculated, subject to the targets, maximums and ratios described in Section 3.500.

The provisions of Sections 4.500 through 4.560 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.501(a) Sale of Beds
A rate adjustment will be made under this section only when a provider has surrendered the right to license these beds for reallocation through the Resource Allocation Program (RAP). Thus, where a provider has sold or transferred his right to license beds, without going through the RAP process, the phase-down and facility closing provisions will not be used to adjust Medicaid rates for the facility that is reducing licensed bed capacity.

The costs of acquiring the right to license beds from another provider are non-reimbursable costs.

4.510 Phase-Down Period
The phase-down period is that time period during which the resident population may be reduced and during which licensed beds are being reduced to the objective bed capacity. The provider shall submit a written plan for the phase-down acceptable to the Department. The plan must specify the objective licensed bed capacity, the expected date by which any phase-down of the resident population is to begin, the amount of the phase-down, and the expected date by which the license will be amended to the objective capacity. The Department shall establish the beginning and ending dates of the phase-down period which may be modified as needed during the phase-down.

4.520 Payment Rates During the Phase-Down Period
Application of this section is optional. Payment rates for the phase-down period shall be retrospectively established under Section 3.000 based on one or more cost reports. No retrospective adjustment shall be available if the phase-down period is less than six months. The cost reporting period(s) shall: (1) begin on, or within the five calendar months before or the five calendar months after, the starting date of the phase-down period, and (2) end on, or within the five calendar months after, the effective date of the amended license at the objective capacity. The retrospective payment rates shall not be effective earlier than the beginning date of the cost reporting period and shall lapse at the end of the reporting period.

The minimum patient days for the administrative expense component (Section 3.250), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500), shall be the greater of patient days at 96.0% occupancy of the objective licensed bed capacity or adjusted patient days during the cost reporting period.

4.530 Payment Rates After the Phase-Down Period
After a provider's license is amended to the objective licensed bed capacity, payment rates may be reestablished based on at least a six-month cost report acceptable to the Department which will begin after the end of the phase-down period or after the end of the cost reporting period used under Section 4.520. Section 4.530 may be applied to the significantly decreased provider which does not receive a retrospective adjustment under Section 4.520. The minimum occupancy standards in Section 3.000 shall apply for determining payment rates after the phase-down period.

4.532 Modified Cost Report Period
The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.360.

4.535 July 1 Payment Rates
A base cost reporting period shall be designated by the Department for establishing the decreased facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the phase-down period includes the July 1 date, then the July payment rates may be established under the retrospective provisions for the phase-down period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the phase-down period, then the Department may designate a more current base cost reporting period for July 1 rates.

4.550 Inflationary Adjustment of Expenses
Cost data from any cost reporting periods described above will be inflated or deflated to the common period described in Section 1.303.

4.560 Major Phase-Down
A major phase-down is: (1) a significant reduction in unrestricted use licensed beds, and (2) a reduction of resident population by 15.0% or more. The determination of the extent of the reduction of resident population shall be based on the average daily resident census, including each bed hold day as one full day, during the cost reporting period which would have been used for establishing payment rates in the first month of the phase-down period if no phase-down rate adjustment had been pursued. Payment rates for such a provider shall be negotiated between the Department and the provider. The provisions of Section 3.000 need not be applied for determining such rates.

4.580 Facility Closings
A provider may choose to phase out its nursing home operation. In such cases, the provider may request, or the Department may require, an adjustment to payment rates for the period of the phase-out. The Department may deny rate adjustments under this section if it determines the provider's phase-out is not desirable or appropriate. Payment rates for such a provider shall be negotiated between the Department and the provider. The provisions of Section 3.000 need not be applied for determining such rates.

4.600 CHANGE IN FACILITY CERTIFICATION OR LICENSURE

4.601 General
If a provider changes its certification, including certification in whole or in part as an ICF-MR or licensure level, the Department may require, or the facility may request, payment rates to be reestablished under Section 3.000. Only the direct care allowance under Section 3.100 and the final rates under Section 3.700 will be recalculated, based on a cost reporting period for patient days and for direct care wages, purchased services and supply expenses. In lieu of reporting new supply expenses, previously allowed supply expenses may be used in the recalculation if acceptable to the Department. The rate computations will consist of two phases: (1) retrospective rates for the change-over period, and (2) post change-over period adjusted rates. The Department may establish interim rates until rates are finalized. The Department may deny reestablishing payment rates if any required Chapter 150 approval was not received. The Chapter 150 rate maximum, per Section 1.600, shall apply, if applicable, to the facility.

4.602 Exceptions
The provisions of Section 4.600 do not apply to a facility certified as a skilled nursing facility (SNF) solely acquiring certification as a nursing facility (NF). Section 4.600 delineates provisions for rate adjustments for facility converting to ICF-MR certification.

4.605 Rates Not Reestablished
If rates are not reestablished upon a change in certification or licensure level, then the payment rate for any added level of care shall be the rate from the next lower level of care.

4.610 Change-Over Period
The change-over period shall be at least a six-month period but no more than a twelve-month period beginning on the first of the month following the month in which the change was effective.

4.620 Payment Rates During Change-Over Period
Application of this section is optional, and if it is not applied, then Section 4.610 will apply. Payment rates for the change-over period may be retrospectively established based on one or more cost reports for the change-over period. The cost reporting period shall: (1) begin on, or within the five calendar months after, the beginning date of the change-over period, and (2) end on, or within the five calendar months after, the end date of the change-over period. The adjusted payment rates shall be effective as of the effective date of the applicable change.

4.630 Payment Rates After the Change-Over Period
After completion of the change-over period, rates for a changed provider may be reestablished based on at least a six-month cost report for patient days and for direct care wages, purchased services and supply expenses. Such cost reporting period shall begin after the end of the change-over period or after the end of the optional cost reporting period used under Section 4.620.

4.632 Modified Cost Report Period
The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year end, reimbursement period, or other cost reports required in different sections of these Methods to permit more efficient or reliable cost reporting.

4.635 July 1 Payment Rates
A base cost reporting period shall be designated by the Department for establishing a changed facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the change-over period includes the July 1 date, then payment rates for July through the end of the change-over period may be established under the retrospective provisions for change-over period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the change-over period, then the Department may designate a more current base cost reporting period for July 1 rates.

4.650 Inflationary Adjustment of Expenses
Cost data from any cost reporting periods described above will be inflated or deflated to the common period described in Section 1.303.

4.690 Special Care Payments/Non Rate Payments

4.691 Ventilator Dependent and Extensive Care Patients
Ventilator dependent patients who can be transferred from a hospital to a nursing home, may be able to receive a comparable level of service at a lower cost in a nursing home. Upon prior approval of the Department, payment of $350 per day, in lieu of the facility's daily rate, shall be paid for such an individual resident for a period determined by the Department if it has been demonstrated to the satisfaction of the Department that the facility can provide care in accordance with the specific patient's needs. This payment does not apply to patients receiving either Continuous Positive Airway or Bi-level Positive Airway pressure ventilator care. Any such payment or recoupment of same is contingent on care being needed and provided. Payment for related extensive care patients prior authorized for care at the $150 rate before July 1, 1989 will continue to receive this rate, with appropriate continued prior authorization for the payment rate year.

4.692 Facilities for the Treatment of Head Injuries

Facilities providing specialized treatment for head injuries may receive a negotiated rate, in lieu of the facility's daily rate, for each resident participating in the head injury program. Allowable cost principles and formula maximums may be applied to rate calculations. Rates may be updated periodically to account for changes in facility costs. The treatment program must be approved by the Department based on established criteria for admission, continuing stay, discharge and other program requirements as determined by the Department. Treatment and rates must be appropriate and receive prior approval of the Department.

Persons interested in a rate for treatment of head injured persons should contact: Administrator, Division of Health Care Financing; P.O. Box 309, Madison WI 53701-0309.

4.694 Residents with AIDS

For requests received prior to October 1, 1993, subject to prior authorization from the Department, a provider accepting a resident diagnosed with AIDS or ARC may receive a payment of $150 per day in lieu of the facility's daily rate. A facility may claim bed hold based on the facility's ISN rates for the empty bed in a semi-private room occupied by an AIDS patient, even if the facility does not meet the occupancy requirements for bed hold described in Section 1.510.

For requests submitted or renewed on or after October 1, 1993, subject to prior authorization from the Department, a provider accepting a resident diagnosed with AIDS may receive a payment of $150 per day in lieu of the facility's daily room rate. Subject to prior authorization by the Department, an additional payment equal to 85% of the facility's ISN rate may be provided for the empty bed in a semi-private room if the AIDS resident's clinical condition requires isolation and a private room is not available.

4.695 Exceptional Supply Needs

In addition to the rates described in Section 4.691, payment for exceptional supply needs for ventilator dependent patients and patients receiving similar care may be paid, if prior authorization is received by the Department.

4.696 Isolation Rate

Subject to prior authorization from the Department, and except for AIDS residents under Section 4.694, a facility accepting a resident with a communicable disease requiring isolation pursuant to HFS 132.51(2)(b), Wis. Adm. Code, may receive an additional payment of the difference between the nursing home's private pay rate for a semi-private room and the private room rate up to $35 per day in addition to the Level of Care rate.

4.697 Property Appraisals

The nursing facility shall submit payment for property appraisal to the contractor under Section 3.531 upon receipt of appraisal invoice from said contractor after the Department has approved the appraisal. The nursing facility provider shall receive payment authorized by the Department upon verification of appraisal cost payment from the contractor.

4.700 SPECIAL PROPERTY TAX ADJUSTMENT

The property tax allowance per Section 3.400 may be adjusted when licensed bed areas are added or replaced or when service areas are added or replaced through construction, conversion, or renovation. This adjustment is available for both significant and non-significant bed increases. The provider may request this adjustment to the property tax allowance if the expense in the previous tax allowance had been based on an assessment date prior to the month of completion of the construction, conversion, or renovation. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is delivered to the Department. The adjustment shall consider only current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the support services allowance in the January 1 payment rate.

4.800 PAYMENT RATE ADJUSTMENT FOR RENOVATION PERIOD

4.801 General

The payment rates may be retrospectively adjusted when a provider temporarily takes a significant number of licensed bed days out-of-use for the purpose of capital renovation of a portion of the facility. Significant is the lesser of 4500 licensed bed days or 25.0% of the annualized licensed bed days of the facility. The adjusted rates shall be effective only for the period of the renovation but not earlier than the first of the month following the month in which the written request for the renovation rate adjustment is delivered to the Department's Division of Health Care Financing. The period of renovation and the number of beds out-of-use must be acceptable to the Department. The period of renovation must be reasonable and will be subject to approval by the Nursing Home Section Chief or delegate upon recommendation from the provider's Medicaid auditor.

4.810 Calculation
The allowances listed below will be retrospectively adjusted for the renovation period in order to consider only the greater of adjusted patient days or patient days at 96.0% occupancy of licensed beds as decreased for the number of beds temporarily out-of-use for the renovation. The adjustment will not consider current expenses, only current patient days for the renovation period. The allowances to be adjusted are the maintenance and security components of the support services allowance (Section 3.200),the administrative expense component of the administrative and general services allowance (Section 3.250), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500). See Section 3.722, item 4, regarding base rates.

4.850 Payment for Services Provided During Temporary Evacuation

4.851 General
If a facility is evacuated due to a natural or man-made disaster, pursuant to a declaration by the Governor of a state of emergency, the following provisions will apply. The nursing home will be responsible for the services provided during the emergency. The Department shall provide retrospective payment for extraordinary expenses that occurred on or after the first day of the base cost reporting period and associated with the temporary evacuation. Extraordinary expenses include payments for direct expenses or purchased services for temporary accommodations and emergency repairs to the nursing home, including costs associated with the evacuated residents incurred by other service providers in providing care, treatment, housing and housing-related services for the evacuated residents. Payment for extraordinary expenses are not subject to the formula maximums under Sections 3.100 through 3.700.

4.852 Payments
The Department will provide prospective payment during the evacuation period and retrospective payment for extraordinary expenses after the evacuation period.

4.8521 Prospective Payment
The payment rates in effect at the time of the disaster will be paid to the evacuated facility for the care of the relocated residents. The Department may establish an interim payment for extraordinary expenses, subject to reconciliation with a retrospective settlement.

4.8522 Retrospective Payment
The Department shall perform a retrospective cost and revenue settlement subsequent to the evacuation period for extraordinary expenses. Payment for extraordinary expenses is contingent upon the facility pursuing all possible sources of revenue, including third party insurance for resident services, property insurance, business interruption insurance and litigation for damages from responsible parties. Payment may be recouped in part or in full if the facility does not make a good faith effort to pursue all possible sources of revenue for extraordinary expenses or if the facility successfully recovers from these sources.

4.853 Revenues
All revenue received from non-Medicaid sources for extraordinary expenses will be used to reduce reported expenses in cost reports during the period of the emergency. Expenses incurred during the emergency will not be allowable for subsequent prospective rate setting activities.

4.854 Short Term Cost Report
The facility shall submit a short term cost report for the period of the evacuation as determined by the Department. The cost report shall include costs associated with the evacuated residents including costs incurred by other service providers as described in Section 4.851.

4.855 Adjusted Patient Days for Rate Calculations after the Evacuation Period
If the base cost report period covered an evacuation period, the calculation of the minimum occupancy test shall be adjusted using the greater of the average occupancy of the three month period prior to the evacuation period or the average occupancy of the three month post-evacuation period for any of the three months following the evacuation period. Patient days for the time period during the evacuation will be deducted from the cost report period. Patient days will then be annualized to obtain the adjusted patient day ratio.

4.856 Bed hold
For bed hold, the criteria in Section 1.500 apply for the three month period following the evacuation except that for the occupancy criteria, the greater of the average patient day occupancy for the three month period prior to the evacuation or the actual for any of the three months following the evacuation period will be used in the bed hold occupancy test.

4.857 Procedure

A. Normal Rate Setting. A 12 month fiscal year cost report including the evacuation time period shall be submitted by the facility. A separate short term cost report consisting of only the expenses and revenues attributable to the evacuation period shall also be submitted. The short term cost report shall then be subtracted from the 12 month cost report and the remaining costs annualized for normal rate setting purposes.

B. Rate Setting for the Evacuation Period. Expenses from the short term cost report shall have any revenues received as a result of insurance, third party liability, law suits, and related revenue sources for the evacuation offset. The portion of the difference attributable to Medicaid residents in excess of the Medicaid daily payment rates shall then result in additional Medicaid reimbursement.

4.858 Facilities Receiving Residents from Evacuated Certified Nursing Homes

A. Patient Days. Patient days for residents received from an evacuated facility will not be included in patient days used for normal rate setting unless the residents are permanently admitted to the receiving facility. Occupancy determinations used for the rate calculations for the payment system will use the three months period prior to admission of these temporary residents.

B. Base Cost Report Effect. Base cost reports including the evacuation period will be adjusted for all expenses billed to the evacuated facility or facilities and/or associated with the evacuated residents.

SECTION 5.000 APPENDICES RELATED TO REIMBURSEMENT

5.100 SUPPLIES AND EQUIPMENT

5.110 General

Dietary Supplies, Incontinence Supplies, Personal Comfort Supplies, Medical Supplies and Equipment, and other similar items reasonably associated with patients' personal living needs in normal and routine nursing home operations are to be provided to Medicaid recipient patients without charge to the patient, the patient's family, or other interested persons. Costs for any such durable and non-durable items are considered to be reimbursed in the facility's daily rate and, therefore, not to be billed or paid for separately.

If a Medicaid recipient specifically requests a brand of a non-durable item:

(1) which the nursing home does not routinely supply, AND

(2) for which there is no equivalent or close substitute brand routinely supplied to patients by the facility,

then the recipient will be expected to pay the actual cost of that item out of personal funds, AFTER being informed in advance that there will be a charge for the item. However, if the non-durable item was ordered by a physician, the recipient cannot be charged. (Reference: HFS 107.09(2)(b), Wis. Adm. Code)

The following is a partial list of items covered by Section 5.000. The Department retains its authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items from the list.

5.120 Dietary Supplies

Artificial sweeteners
Diet supplements (Metrecal, Ensure, Vivonex and related products)
Salt substitutes (Neocurtasal, etc.)
Sugar substitutes

(Note: The cost of dietary supplies is included in the support services allowance.)

5.130 Incontinence Supplies

Catheters (Foley and Condom), catheter sets, component parts, (tubing, urine collection apparatus, e.g., bags, bed bags, etc.)

Diapers - disposable and reusable (including purchased diaper service)

Underpads - disposable and reusable

5.140 Personal Comfort Items and Medical Supplies and Equipment

Alcohols (rubbing antiseptics and swabs)
Analgesic rubs (Ben-Gay, Infrarub, Vicks Vaporub, etc.)
Antiseptics (Betadine, iodine, mercurochrome, merthiolate and similar products)

Baby, comfort and foot powders
Body lotions, skin lubricants and moisturizers (olive oil, Nivea oil and cream, Lubath, Alpha-Keri, Keri Lotion, etc.)
Blood glucose testing supplies, including strips

Cotton tipped applicators and cotton balls

Deodorants
Denture products (adhesives and cleaning products)
Disposable tissues (Kleenex, etc.)
Dressings (adhesive pads, abdominal pads, gauze pads and rolls, eye pads, sanitary pads, stockinette, Opsite and related items)

Enema administration apparatus

Gloves (latex and vinyl)

Hydrogen peroxide

Lemon or glycerin swabs
Lubricating jellies (Vaseline, KY jelly, etc.)

Oral hygiene products (dental floss, toothpaste, toothbrush, Waterpik)

Phosphate enemas
Plastic or adhesive bandages (e.g. Band-aids)

Shampoos (except specialized shampoos as Selsun and similar products)
Soaps (antiseptic and non-antiseptic)
Straws (paper and plastic)
Syringes and needles, Lancets (disposable and reusable)

Tapes, all types
Tincture of benzoin
Tongue depressors
Tracheotomy care sets and suction catheters
Tube feeding sets and components part

NOTE: Although these are the most common of the personal comfort items, this is not intended to be an all-inclusive list. Exceptional supply needs subject to prior authorization are based upon the Department's guidelines pursuant to Section 4.695.

5.150 All Non-Expendable, Reusable Materials

Abdominal binder
Abdominal support
Adaptive dressing equipment
Adaptive eating utensils
Adaptive hygiene equipment
Air cleaner
Air splints
All non-expendable, reusable materials (bedpans, thermometers, Towels, linen, ace bandages, rubber pants, etc.)
Alternating pressure pumps
Apnea monitor
Aquaped (K pad)

Bath bench
Bath lifts
Bath sling
Bed, electric
Bed, hospital
Bed rails
Blood glucose monitor

Commodes
Crib, hospital-type
Crib with enclosed top
Cushions, all types, wheelchairs

Elbow protectors
Elevated toilet seats
Enuretic alarm
Exercise equipment
Exercycle (exercise bike)

Floor stand, trapeze
Floor stand, weights
Flotation pads
Food pumps
Foot boards (model)
Foot protectors

Geriatric chairs
Gait belts

Hand cones
Hand splints, soft
Hosiery, including support and thrombo-embolytic disease stockings
Hoyer or other hydraulic or non-hydraulic lift
Humidifier
IPPB (Intermittent positive pressure machine)
IV Poles

Lamp, heat and ultraviolet Lap boards/trays, wheelchair

Mat, exercise
Mattress, air, alternating pressure, gel, foam
Mattress pads
Lower extremity splints/positioners (e.g. mulitodus)

Name tags

Oxygen masks, canulas, tubing, nebulizer, flow meter

Patient lifts
Positioning equipment for wheelchairs, chairs and beds
Prone standers
Pulse oximeter

Reachers
Restraints
Roho, Jay or similar flotation cushion

Safety rails – hallways, bathroom areas (tub, toilet, shower)
Sitz baths – portable
Sliding boards
Standing tables
Suction machine (standard)

TENS units
Transfer devices
Traction apparatus
Trapeze
Tub, rail

Vaporizer, room
Volumetric pump

Walkers, canes, crutches (including quad-canes)
Water mattress
Wheelchairs, all manual
Wheelchairs, power (See Sec 5.160)
Whirlpool
Wrist bands and alarm systems

5.160 Durable Medical Equipment and Wheelchairs - Exceptions

5.162 General
Durable medical equipment and wheelchairs reasonably associated with a patient's personal living needs in normal and routine nursing home operations are to be provided to Medicaid recipients without charge to the patient, the patient's family, or other interested persons. The cost of all wheelchairs, including geriatric chairs but excluding motorized wheelchairs or vehicles, is included in the nursing home payment rate.

Under certain exceptions, durable medical equipment (DME) and wheelchairs may be billed separately by the supplier if prior authorized. The prior authorization request must document the need for the item according to the exception criteria described below.

5.164 Durable Medical Equipment
Exceptions to permit separate payment for DME may be allowed by the Department if the DME is personalized or custom-made for a recipient resident and is used by the resident on an individual basis for hygienic or other reasons. These items include orthoses, prostheses (including hearing aids), orthopedic or corrective shoes, or pressure relief beds.

5.166 Special Adaptive Positioning or Electric Wheelchairs
The Department may permit separate payment for a special adaptive positioning or electric wheelchair, while a recipient resides in a nursing home, if the wheelchair is prescribed by a physician and the following criteria are met:

1. The wheelchair is personalized in nature or is custom-made for a patient and is used by the resident on an individual basis for hygienic or other reasons, AND

2. The special adaptive positioning wheelchair or electric wheelchair is justified by the diagnosis and prognosis and the occupational or vocational activities of the recipient (i.e., educational, therapeutic involvement).

Exceptions for wheelchairs may be allowed for the recipient who is about to transfer from a nursing home to an alternate and more independent setting.

5.167 References
Information regarding DME and wheelchairs is contained in HFS 107.24, Wis. Adm. Code, and in the DME Provider Handbook. (For more information on prior authorization, see HFS 107.02(3), Wis. Adm. Code.)

5.200 OVER-THE-COUNTER DRUGS

5.210 General
Certain over-the-counter drugs are to be provided to Medicaid recipient patients without charge to the patient, the patient's family, or other interested persons. Costs for any such over-the-counter drugs are considered to be reimbursed in the facility's daily rate and, therefore, not to be billed or paid for separately.

The following is a partial list of items covered by Section 5.200. The Department retains its authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items from the list.

Aspirin	Vaginal products	Hemorrhoidal products
Ibuprofen	Digestive aids	Antibiotics
Vitamins	Saliva substitutes	Pediculicides
Non-covered cough & cold products	Acetaminophen	Decubitus treatments
Non-covered ophthalmic products	Laxatives	Quinine
Topical steroids	Minerals	Antidiarrheals
Antifungals	Antihistamines	

The above list does not represent the entire list of drugs covered under Section 5.200 and other non-covered over-the-counter drugs may be added to this section. Over-the-counter drugs covered under this section must be on the Division of Health Care Financing's approved OTC list or index.

5.300 COST REPORT INFLATION AND DEFLATION FACTORS

Inflation and deflation factors to adjust expenses from nursing home cost reports to the common period are given below. The common period is the twelve-month period prior to the payment rate year. The factors listed below apply to annual nursing home cost reports ending in the following months.

5.310 Direct Care

	January February March 2000	April May June 2000	July August September 2000	October November December 2000
Wages	6.7%	5.3%	3.9%	2.5%
Fringe Benefits	4.4%	3.7%	2.8%	1.8%
Supplies	4.1%	3.2%	2.3%	1.5%
Purchased Services	4.0%	3.2%	2.4%	1.6%

5.320 Support Services

	January February March 2000	April May June 2000	July August September 2000	October November December 2000
Composite Support Service Expenses	5.0%	3.9%	2.9%	1.9%

5.330 Administrative and General Services

	January February March 2000	April May June 2000	July August September 2000	October November December 2000
Composite Administrative and General Services Expenses	5.0%	3.9%	2.9%	1.9%

5.340 Fuels and Utilities

	January February March 2000	April May June 2000	July August September 2000	October November December 2000
Fuel Oil	31.4%	21.6%	12.8%	4.2%
Natural Gas	40.0%	36.1%	30.0%	21.0%
LP Gas	40.0%	36.1%	30.0%	21.0%
Coal	31.4%	21.6%	12.8%	4.2%
Electricity	3.2%	3.0%	2.3%	1.8%
Water and Sewer	3.5%	2.9%	2.2%	1.5%

5.350 Over-the-Counter Drugs

Inflation rate to the common period	4.1%	3.2%	2.3%	1.5%

5.360 Alternate Cost Report Periods

The Department may establish alternate inflation or deflation factors for cost reporting periods not listed above.

5.400 DIRECT CARE PAYMENT PARAMETERS

5.410 Labor Factors

County	Labor Factor	Alternate Factor
Adams	0.949	0.995
Ashland	0.949	0.942
Barron – 547xx	0.949	0.957
Barron – 548xx	0.949	0.942
Bayfield	0.949	0.942
Brown	1.015	1.011
Buffalo – 546xx	0.949	0.942
Buffalo – 547xx	0.949	0.957
Burnett	0.949	0.942
Calumet	1.016	0.998
Chippewa	0.973	0.979
Clark	0.949	0.957
Columbia	0.949	0.995
Crawford	0.949	0.942
Dane	1.072	1.127
Dodge	0.949	0.995
Door	0.949	0.957
Douglas	0.927	1.057
Dunn	0.949	0.957
Eau Claire	0.973	0.979
Florence	0.949	0.957
Fond du Lac – 530xx	0.949	0.995
Fond du Lac – 549xx	0.949	0.957
Forest	0.949	0.942
Grant - 535xx	0.949	0.995
Grant - 538xx	0.949	0.942
Green	0.949	0.995
Green Lake – 539xx	0.949	0.995
Green Lake – 549xx	0.949	0.957
Iowa	0.949	0.995
Iron	0.949	0.942
Jackson	0.949	0.942
Jefferson	0.949	0.995
Juneau	0.949	0.995
Kenosha	0.948	1.040
Kewaunee	0.949	0.957
La Crosse	0.971	1.010
Lafayette	0.949	0.995
Langlade	0.949	0.957
Lincoln	0.949	0.957
Manitowoc	0.949	0.957
Marathon	1.031	1.025
Marinette	0.949	0.957
Marquette	0.949	0.995
Milwaukee	1.092	1.089
Monroe	0.949	0.942
Oconto	0.949	0.957
Oneida	0.949	0.942
Outagamie	1.016	0.998
Ozaukee	1.092	1.089
Pepin	0.949	0.957
Pierce	1.016	1.183
Polk – 540xx	0.949	0.995
Polk – 548xx	0.949	0.942
Portage	0.949	0.957
Price	0.949	0.942
Racine	0.962	1.051
Richland	0.949	0.995
Rock	1.050	1.038
Rusk	0.949	0.942
St. Croix	1.016	1.183
Sauk	0.949	0.995
Sawyer	0.949	0.942
Shawano	0.949	0.957
Sheboygan	1.017	0.986
Taylor	0.949	0.957
Trempealeau – 546xx	0.949	0.942
Trempealeau – 547xx	0.949	0.957
Vernon	0.949	0.942
Vilas	0.949	0.942
Walworth	0.949	0.995
Washburn	0.949	0.942
Washington	1.092	1.089
Waukesha	1.092	1.089
Waupaca	0.949	0.957
Waushara	0.949	0.957
Winnebago	1.016	0.998
Wood	0.949	0.957
Menominee	0.949	0.957

5.420 Case Mix Weights

Level of Care	Case Mix Weight
DD3	1.10
DD2	1.55
DD1B	1.85
DD1A	1.85
ICF4	0.25
ICF3	0.25
ICF2	0.50
ICF1	0.70
SNF	1.00
ISN	1.30
Ventilator	4.00

5.430 Statewide Direct Care Base
The statewide direct care base is $60.73.
The alternate direct care base is $57.42

5.440 Statewide Direct Care Cost Inflation Increment
The statewide direct care inflation increment is $ 2.16

5.500 SUPPORT SERVICES PAYMENT PARAMETERS

5.510 Support Services Maximum and Increment

Target T1 = $21.01 for common period.
Target T2 = $21.74 for common period.
Increment = $ 0.73 to adjust costs to payment rate year.

5.550 ADMINISTRATIVE AND GENERAL SERVICES PAYMENT PARAMETERS

5.551 Administrative and General Services Maximums and Increment

Maximum for Providers over 40 beds for rate setting (Section 3.040) = $12.59
Maximum for Providers with 40 or fewer beds for rate setting (Section 3.040) = $12.59
Increment = $ 0.42

5.600 FUEL AND UTILITY PAYMENT PARAMETERS

5.610 Fuel and Utility Targets

The following fuel and utility expense targets are for the common period.

Target	Counties in Region
Region I = $2.66	Bayfield, Douglas
Region II = $2.65	Ashland, Iron, Oneida, Price, Vilas
Region III = $2.58	Barron, Burnett, Chippewa, Clark, Florence, Forest, Langlade, Lincoln, Marathon, Marinette, Menominee, Oconto, Polk, Rusk, Sawyer, Shawano, Taylor, Washburn
Region IV = $2.63	Adams, Brown, Buffalo, Calumet, Door, Dunn, Eau Claire, Fond du Lac, Green Lake, Jackson, Juneau, Kewaunee, La Crosse, Manitowoc, Marquette, Monroe, Outagamie, Pepin, Pierce, Portage, Sheboygan, St. Croix, Trempealeau, Waupaca, Waushara, Winnebago, Wood
Region V = $2.53	Columbia, Crawford, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Richland, Rock, Sauk, Vernon
Region VI = $2.51	Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Waukesha

5.612 Fuel and Utility Increase Allowance
The inflation factor to adjust payment and expense to the payment rate year shall be 4.0%.

5.700 PROPERTY TAX PAYMENT PARAMETERS

5.710 Real Estate Tax and Municipal Fees Inflation Rates.

Inflation for real estate taxes = 7.0%

Inflation for municipal fees = 7.0%

5.800 PROPERTY PAYMENT PARAMETERS

5.810 Property Increments

(a) ICF-MRs $3.29
(b) NFs $1.06

For distinct part facilities only, the property increment will be a blended increment based on ICF-MR and NF patient days in the cost reporting period.

5.820 Service Factors

(a) T1 6% of equalized value (after adjustments under Sections 3.531(a) and (b)
(b) T2 7.5% of equalized value (after adjustments under Sections 3.531(a) and (b)

5.830 Equalized Value

Equalized Value: $51,400

5.840 Cost Share Value

5.840(a) Cost Share Value: 20%

5.840(b) Cost Share Value for nursing facilities referenced in Sections 3.070 and 3.532: 40%

5.850 Incentive Value

Incentive Value: 20%

5.900 OTHER PAYMENT PARAMETERS

5.910 OTC Increase Allowance
The inflation factor to adjust payment and expense to the payment rate year shall be 2.6%.
OTC Target = $0.40

5.920 Exceptional Medicaid/Medicare Utilization Incentive
Base allowance for the exceptional Medicaid/Medicare incentive $2.12

5.930 Private Room Incentive
Base allowance for the private room incentive =$1.00
Renovation allowance for the private room incentive =$2.00

SECTION 6.000 MEDICAID NURSING HOME PAYMENT RATE METHODS ADDENDUM FOR STATE PLAN PURPOSES

6.100 COST FINDING AND REPORTING

6.110 Provider Cost Reports

All NF and ICF-MR facilities, which are certified to participate in the Medicaid program, must complete the uniform cost report prescribed by the Department. Completed cost reports must be submitted to the Department normally no later than three months after the close of each cost reporting period. An additional 30 days may be allowed to facilities that have a certified audit completed for the period of the cost report. A copy of the audit report including certified financial statements and notes thereto must be submitted with the cost report. The cost of central administrative services generally are to be reported using the Department's home office cost allocation report, a Medicare cost allocation report, or another cost allocation report acceptable to the Department.

The cost reports, which will be based on the uniform chart of accounts approved by the Department, must be completed in accordance with generally accepted accounting principles (GAAP) and the accrual method of accounting. The Department may allow exceptions to reporting under certain specific accounting standards. Facilities under 30 beds may be exempted from accruing certain items. Governmental institutions normally operated on a cash method of accounting may use this method, if they so desire.

Also see Section 1.170 of this Methods regarding cost reporting requirements.

6.120 Cost-Finding Method

The cost-finding method used by NF and ICF-MR facilities is described in the cost report. The cost report requires basic cost and statistical information used in the calculations of the payment rates.

6.130 Actual Costs Considered

The Methods referenced in this Methods are intended to take into account the reasonable, actual costs of nursing home services and to provide rates which will be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated. This level is determined from study and analysis of cost reports submitted by facilities. Such an analysis may include the use of representative sample of facilities' cost reports.

6.200 AUDITS

6.210 General

The Department will periodically audit cost reports submitted by nursing home providers and the related financial and statistical records of the providers. The providers selected for on-site audit and the scope of the on-site audit will be determined by: (1) a desk analysis of the cost report submitted by each provider or (2) other criteria determined by the Department. On-site audits will generally be selective in scope.

6.220 Desk Analysis of Cost Reports

Upon submission of the cost reports to the Department, desk reviews will be conducted by Department auditors to determine that, to the extent possible and necessary for rate-setting: (1) only those expense items that the Department has specified as allowable costs are included in the computation of the costs of the nursing home services and (2) expenses have been reliably reported.

Based on the results of the cost report analysis, some of the submitted cost reports will be selected for further on-site examination. The audit will be limited to specific items in the cost report based on the desk analysis or other observations.

6.230 Overpayments Identified and Recovered

Overpayments identified in the audit of a nursing home provider's cost report(s) will be recovered from the provider. Immaterial amounts may not be recovered.

6.300 SEPARATELY BILLABLE ANCILLARY ITEMS

6.310 Items

The costs for the following items may be billed separately by the nursing home and, thus, are not included in the calculation of the daily payment rate of the nursing home:

a. Tracheostomy and ventilatory supplies and related equipment, subject to guidelines and limitations published by the Department;

b. Transportation provided by a nursing home to permit a recipient to obtain health treatment or care if the treatment or care is prescribed by a physician as medically necessary and is performed at a physician's office, clinic, or other recognized medical treatment center. Such transportation may be provided in the nursing home's own controlled equipment and by its staff, or by common carrier, such as bus or taxi.

c. Oxygen, as provided in cubic feet, pounds, or tanks, or the daily rental of oxygen concentrators using the HCFA 1500 claim form. (The nursing home will be subject to maximum fees for these services, and prior authorization is required for more than 30 days rental of an oxygen concentrator.)

6.320 Reimbursement Manner

The costs of services and materials identified above which are provided to patient recipients shall be reimbursed in the following manner:

a. Claims shall be submitted under the nursing home's provider number, and shall appear on the same claim form used for claiming reimbursement at the daily nursing home rate.

b. The items shall either have been prescribed in writing by the attending physician or the physician's entry in the medical records or nursing charts shall make the need for the items obvious.

c. The amounts billed shall reflect the fact that the nursing home has taken advantage of the benefits associated with quantity purchasing.

d. Reimbursement for questionable materials and services shall be decided by the Department.

e. Claims for transportation shall show the name and address of any treatment center to which the patient recipient was transported and the total number of miles to and from the treatment center.

f. The amount charged for transportation may not include the cost the facility's staff time, and shall be for an actual mileage amount.

6.400 REIMBURSEMENT OF OUT-OF-STATE NURSING HOMES

Nursing home services may be provided to a Wisconsin Medicaid recipient in a nursing home located outside the State of Wisconsin, provided the home is certified in the Medicaid program of the other state.

Payment for temporary coverage of the Wisconsin recipient at the out-of-state home will be at a standardized payment rate for the month of admission and for a maximum of three full calendar months after the admission date. The Department will establish the standardized payment rate based on the approximate average payment rate for a comparable level of care as paid to Wisconsin nursing homes in the July preceding the admission date.

A payment rate more specific to the out-of-state nursing home may be established if: (1) the temporary coverage payment rate is not appropriate for the patient; (2) the temporary rate is not appropriate for the nursing home; (3) the facility requests a specific payment rate; or (4) the period of the temporary payment rate has been completed.

In determining a different rate, the Department may take into consideration: Medicaid rates which are being paid to the facility by states other than Wisconsin; payment for similar services in Wisconsin; available information on the cost of the facility's operation; and any specialized services or unique treatment regimens which may not be available in Wisconsin at a similar or lesser cost.

Ancillary items listed in Section 3.800 may be separately reimbursed to the out-of-state nursing home, if coverage for such materials or services is not included in the daily care rate.

MEDICAID NURSING HOME PAYMENT RATE METHODS

ADDENDUM: COSTS FOR OBRA '87 COMPLIANCE

6.500 REIMBURSEMENT OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA '87) REQUIREMENTS

6.503 Payments for OBRA '87 Requirements

Upon compliance, the allowance under Section 3.100 has been adjusted for facilities over 120 beds for the addition of qualified social workers. Notwithstanding Section 3.121, the facility's actual allowable direct care expenses shall be inflated from the cost reporting period to the common period, to fund costs incurred to comply with OBRA '87, as well as the annual estimated inflationary increase.

In Section 3.251 describing the calculation for Administrative and General Services allowances, the expense factor is defined as the facility's allowable expenses (per patient day) adjusted by a composite inflation factor, including annual inflation and cost inflation to comply with OBRA '87 applied to the common period.

6.503(a) For ICF facilities converting to NF facilities

The related direct care costs have been included in the allowable costs reported under Section 4.600.

6.506 Compliance with OBRA '87 Requirements

The Department's Bureau of Quality Assurance determines compliance with OBRA '87 for each nursing facility. Allowances under Section 6.503 of these Methods will only recognize costs determined by Bureau of Quality Assurance to be related to OBRA '87 compliance.

6.507 Professional Nurse Staffing Requirement

Nursing homes' rates have been adjusted for the incremental costs to meet OBRA requirements relating to having a professional nurse (RN or LPN) on duty at all times. One of the following conditions had to be met to be eligible for the adjustment:

a. The facility has 50 or fewer licensed beds, or

b. The facility changed its certification from intermediate care facility (ICF) to nursing facility (NF) on or after October 1, 1990.

The adjustment may be effective on the first day of the month following the date the facility fulfilled the staffing requirement. The adjustment may allow payments for direct care services to exceed the maximums which are applied under Section 3.100, by 20 percent. The costs have now been incorporated in the base cost reports for qualifying nursing homes, and the adjustment has been addressed through incorporating the provisions in the Methods in Section 3.122.

6.600 Uses of Federal Funds

Consistent with practices since the inception of the Inter-Governmental Transfer program in 1985, all Medicaid Federal Financial Participation (FFP) claimed for nursing home services, including FFP claimed based on operating deficits of government-owned facilities, shall be used to reimburse Medicaid covered services in Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded for Medicaid eligible residents.

COMPARISON OF OBRA '87 AND OBRA '90 WITH WISCONSIN NURSING HOME REQUIREMENTS
(CH. HFS WIS. ADMIN. CODE)

1. Nurse Staffing

   State regulations under HFS 132.62(2) and (3), Wis. Adm. Code, comply with OBRA '87 requirements in all areas.

2. Other Staffing

   Requirements in this area with the exception of social worker staffing, are met by State regulations under HFS 132.63 (dietary services), 64 (rehabilitative services), .65 (pharmaceutical services), .66 (laboratory, radiologic and blood services), .67 (dental services), and .69 (activities), Wis. Adm. Code. Medical records requirements are fulfilled under HFS 132.45, Wis. Adm. Code. Currently, Wisconsin requires either a full-time or part-time social worker (HFS 132.68(2), Wis. Adm. Code), while OBRA mandates at least a full-time social worker for facilities over 120 beds.

3. Continuing Education for Nurse Aides

   HFS 129, Wis. Adm. Code, effective July 1, 1991, complies with all OBRA requirements.

4. Resident Assessment

   Current State requirements at HFS 132.52(3) through (6), Wis. Adm. Code, require evaluation and assessment at the time of admission to the facility. A minimum data set and resident assessment protocols are required along with a quarterly review and annual reassessment. The State has specified the HCFA MDS as the resident assessment instrument for all nursing homes in the State to use.

5. Plans of Care

   The initial Plan of Care (HFS 132.52(4), Wis. Adm. Code) is required under state code upon admission to a facility and, within 4 weeks of admission, a care plan must be written. The care plan must be reviewed, evaluated, and updated as necessary (HFS 132.60(8), Wis. Adm. Code). Required areas/contents of the care plan correspond to OBRA '87 requirements. While timing of the comprehensive plan differs from OBRA '87, other requirements, in general, comply.

6. Resident Personal Funds

   State regulation under HFS 132.31, Wis. Adm. Code, requires all resident funds be deposited in an interest-bearing account with separate accounting for each resident. A quarterly report must be made to each resident except in cases of discretionary expenditure authority for the facility, in which case, reporting may be monthly. To comply with OBRA '87, facilities will have to establish a second, non-interest bearing account or petty cash fund for amounts under $50 and re-adjust for current interest-bearing monies under $50. Further, facilities must notify resident when his/her account reaches $200 less than the MA eligibility limits. Monitoring compliance with these requirements performed by the state survey agency and the state Medicaid agency is based on an interagency agreement.

7. Resident Rights

   All State requirements for facilities meet the OBRA requirements regarding all residents rights issues. However, the State continues to work with facilities to reduce both physical and chemical restraint use in nursing facilities.

8. Compliance with the Definition of a Nursing Facility

   All facilities are in compliance with the OBRA definition of a nursing facility or operating under a waiver of specific portions of the regulations.

SUMMARY OF OBRA NURSING HOME COMPLIANCE

1. Nurse Staffing

   - No additional cost.

2. Plans for Care

   - No additional cost.

3. Resident Assessments

   - No additional cost will be incurred in this rate period.

4. Other Staffing Requirements (Social Workers)

   - No additional cost.

5. Continuing Educations (Nurses Aides)

   - No additional cost.

6. Resident Rights (freedom from restraints)

   - No additional cost will be incurred in this rate period.

7. Personal Funds

   - No additional cost.

8a. Physical Plant Projects (HVAC and ancillary space)

   - No additional costs will be incurred during this rate period.

8b. ICF Conversions

   - No additional cost in this rate period.

9. Services Required to Ensure the Highest Physical, Mental and Psychosocial Well-Being of Each Resident

   - No additional cost.

FY 00 ESTIMATED COST = $ -0- OR $ -0- PPD

ANALYSIS AND SUMMARY FOR OBRA '87 AND '90

Wisconsin has reviewed its estimates for the cost of implementing the requirements of OBRA '87 and OBRA '90. The following represents the cost analysis and summary of OBRA implementation for the payment rate year.

Several sources were used to estimate costs of OBRA '87. Primarily these are the survey guidelines issued by HCFA reviewed against costs itemized on nursing facility cost reports, two clinical resident surveys conducted in a group of Wisconsin's nursing facilities, and an analysis of facility staffing collected during annual facility surveys. For both the resident assessment system and freedom from restraint requirement, resident sampling was conducted to estimate additional staff time needed to conduct the activities necessary to comply with the new requirements. This information is updated with survey information as it becomes available and cost report information that document staffing in NFs and ICF-MRs. We believe that facilities completed implementation of OBRA on or before October 1, 1990, as required by federal law. The cost reports for rate setting are from facility fiscal years subsequent to 1990; therefore, the cost of implementing the requirements of OBRA '87 and OBRA '90 are now totally incorporated into the cost reports that are used for the payment plan.

1. Nurse Staffing: For the facilities licensed and certified as SNF (NF) prior to implementation of OBRA '87, it is determined that no additional costs are being incurred since current state regulations already comply with OBRA '87 requirements in this area. (See Comparison on Current Wisconsin and OBRA '87 Requirements.)

2. Plans of Care: It is anticipated that no additional costs are being incurred to comply with the Plan of Care Requirements. (See Comparison of Current Wisconsin and OBRA '87 Requirements.)

3. Resident Assessments: The agency, in a joint effort with the nursing home industry, conducted a sample survey of residents in ten nursing facilities to determine the additional time necessary to fulfill the requirements to complete the new MDS and RAP. An average of 2.63 additional nursing hours were needed, an average 1.13 social work hours and an average 0.74 activity hours were reported. Based on the average salary and fringe benefit costs from 1988 cost reports, inflated to the 1990-91 year, the estimated implementation cost was $2.0 million. It is assumed that the total cost of implementation has been reported on facility cost reports that will be used for establishing rates.

4. Other Staffing: Survey results indicate no additional needs beyond the funding made available during the 1990-91 rate year.

5. Continuing Education for Nurses Aides: Based on revised regulations, continuing education requirements for nurses aides have been significantly reduced over original OBRA estimates. No additional funding is required.

6. Resident Rights: Implementation of this requirement was completed during previous cost report periods.

7. Resident Personal Funds: Implementation of these requirements indicate no additional funding will be necessary for the payment rate year.

8. Compliance with the Definition of "Nursing Facility":

   A. Physical Plant Requirements. Review of the new Federal Survey Guidelines indicated that major renovations may be necessary for a number of facilities to bring their heating, ventilation and air conditioning (HVAC) systems up to compliance with OBRA '87 temperature requirements. To estimate costs, 18 previous projects were identified and the average cost of these projects was used as the cost of new projects. In addition, it is anticipated that some facilities will have to construct additional spaces for activities, therapies and other ancillary services. The cost basis for these construction projects to "ancillary areas" is estimated at the equivalent of 50% of the construction of new bed areas.

   Total necessary HVAC renovation and ancillary space additions are expected to cost $3.2 million in prior rate years. We believe that all facilities are now in compliance with the definition of a nursing facility and costs have been incorporated into the cost reports.

   B. ICF Conversion. The basis for this estimate is the change in rates for 11 facilities converting from ICF to SNF licensure since July 1, 1987, inflated forward. The average change was applied to patient days for the remaining 14 ICF facilities at an estimated cost of $1.092 million. All conversions have been completed prior to this rate period; therefore, their conversion costs are included in the cost reports that will be used to establish rates for this reimbursement period.

9. Services Required to Ensure the Highest Physical, Mental and Psychosocial Well-Being of Each Resident: The costs of this requirement are included in the resident direct care costs estimated in items 1-6. The objective of requirements included in these items is the maximization of physical, mental and psychosocial well-being of all residents.

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